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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

SHAIN A. CUBER, M.D.

Holder of License No. 26775
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-02-0707A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 10, 2003. Shain A. Cuber, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Respondent is the holder of License No. 26775 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-02-0707A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a 27 year-old male patient ("CR").
4. On October 9, 1999 CR presented to the emergency room at John C. Lincoln Hospital – Deer Valley ("Hospital") with a laceration of his left arm after being struck in the left arm with a piece of sheet metal. The emergency room physician noted a deficit of sensation and movement in CR's ring and small fingers of the left hand with a

1 deep laceration to the upper medial aspect of his left arm. The laceration was closed in
2 the emergency room and CR was referred to Respondent, the on-call plastic surgeon for
3 the emergency room. Respondent noted that during his tenure at Hospital he and his
4 senior associate were the only plastic surgeons on staff at Hospital who performed any
5 kind of nerve repairs to the hand or upper extremities.

6 5. CR presented to Respondent on October 11, 1999 for evaluation and care
7 of the laceration. Respondent testified that upon examination CR had essentially no
8 motor or sensory function referable to the ulnar nerve. Specifically, Respondent noted an
9 absence in the sensation of the medial aspect of the hand, small finger and ulnar aspect
10 of the ring finger – the portion of the hand and fingers that are innervated by the ulnar
11 nerve. Respondent also noted that CR had very little to no movement of the intrinsic
12 muscles of the hand that are also innervated by the ulnar nerve.

13 6. On October 14, 1999 Respondent performed an ulnar nerve repair on CR's
14 arm. CR remained in Respondent's care. CR subsequently developed an ulnar nerve
15 neuroma. On March 10, 2000 Respondent resected the neuroma and attempted a micro
16 repair of the left ulnar nerve.

17 7. Respondent was asked what he expected to find during surgery based on
18 his clinical examination of CR. Respondent stated that he expected the ulnar nerve to be
19 lacerated, completely transected. Respondent testified that his findings during surgery
20 were that a portion of the triceps muscle was lacerated and that the ulnar nerve was
21 lacerated approximately 90 percent of its circumference. Respondent noted that he then
22 proceeded to repair the ulnar nerve and triceps muscle by using loupe magnification to
23 place 8-0 nylon sutures in the epineural layer to align the nerve fibers.

24 8. Respondent was asked whether the procedure he performed would have
25 been the applicable standard of care in 1999 for a complete nerve transection of a major

1 peripheral nerve. Respondent stated that in retrospect it was not and it would have been
2 more appropriate to do a group fascicular repair.

3 9. Respondent was asked whether, in 1999, he was comfortable taking care of
4 peripheral nerve lacerations. Respondent stated that with his training and experience he
5 felt comfortable. Also, Respondent stated that those patients whose peripheral nerve
6 injuries that he had repaired previous to CR had fairly good outcomes.

7 10. Respondent was asked whether after the repair was completed would it
8 have been appropriate to find a way to take the tension off the nerve. Respondent noted
9 that at the time of surgery he did not feel there was any tension on the nerve.
10 Respondent was asked whether the nerve is particularly vulnerable in the ulnar groove at
11 the elbow. Respondent stated that in that area the ulnar nerve is susceptible to
12 compression, but CR's laceration was proximal to the elbow and he felt that he could
13 avoid tension just by positioning CR's elbow in extension.

14 11. Respondent was asked whether taking care of ulnar nerve lacerations was
15 a part of his training either as a general surgery resident or a plastic surgery fellow.
16 Respondent stated that it was part of his training as a plastic surgery fellow, but that this
17 type of injury occurred rarely and CR's case was probably the only case he has seen in
18 his practice. The Board noted that the injury is rare and inquired as to what preparation
19 Respondent did before proceeding with treatment. Respondent stated that he looked in
20 the standard textbook for hand surgery and could find no reference or mention of
21 performing an anterior submuscular transposition when repairing the ulnar nerve at this
22 level. Respondent noted that fascicular repair was mentioned. Respondent was asked
23 why he did not do a fascicular repair. Respondent stated that he did not do so because
24 at the time of surgery he felt he was able to get adequate alignment of the fascicles with
25 an epineural repair.

1 12. Respondent stated that he put the elbow through some range of motion and
2 noticed that putting it in flexion did create tension at the site of the nerve repair and,
3 therefore, he splintered CR in extension. Respondent stated that he planned to leave CR
4 in extension for roughly three weeks. Respondent was asked if three weeks was
5 sufficient time for the epineural repair to heal so that you can bend the elbow.
6 Respondent stated that in CR's situation there is no happy medium because you can't
7 leave the elbow joint immobilized until you have got adequate strength at the nerve
8 repair. And you have to start doing some range of motion at three weeks because
9 otherwise you run the risk of creating too much stiffness in the elbow.

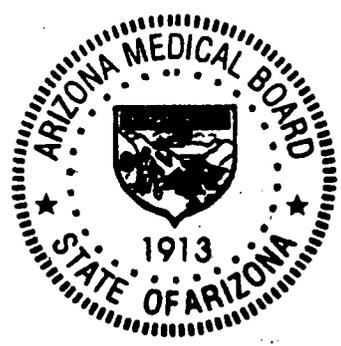
10 13. Respondent was asked if CR improved in terms of ulnar function after the
11 surgery. Respondent stated that CR never improved. Respondent was asked if CR's
12 failure to improve concerned him. Respondent stated that it was definitely concerning
13 and he followed the lack of improvement by following motor and sensory examinations
14 and following the Tinel's sign. Respondent stated that in retrospect he should have
15 performed electrodiagnostic studies.

16 14. Respondent testified in summary that looking back on CR's case there were
17 a number of things he would have done differently. At the initial surgery Respondent
18 stated he should have made an attempt to do a group fascicular repair. Respondent also
19 noted that this type of rare injury has a poor prognosis in terms of functional recovery.
20 Respondent noted that if he had managed CR differently CR may not have required
21 eventual nerve grafting, but that the overwhelming majority of patients with this type of
22 nerve injury develop the kind of claw deformity that is very characteristic of ulnar nerve
23 lesions. Respondent noted that because this deformity is very characteristic CR would
24 have gone on to require the two additional surgical procedures regardless of how
25 Respondent performed his procedure.

1 review must be filed with the Board's Executive Director within thirty (30) days after
2 service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient
3 reasons for granting a rehearing or review. Service of this order is effective five (5) days
4 after date of mailing. If a motion for rehearing or review is not filed, the Board's Order
5 becomes effective thirty-five (35) days after it is mailed to Respondent.

6 Respondent is further notified that the filing of a motion for rehearing or review is
7 required to preserve any rights of appeal to the Superior Court.

8 DATED this 17th day of February, 2004.



10 THE ARIZONA MEDICAL BOARD

11 By Amade Biedl
12 for BARRY A. CASSIDY, Ph.D., PA-C
13 Executive Director
14

15 ORIGINAL of the foregoing filed this
16 17th day of February, 2004 with:

17 Arizona Medical Board
18 9545 East Doubletree Ranch Road
19 Scottsdale, Arizona 85258

19 Executed copy of the foregoing
20 mailed by U.S. Certified Mail this
21 17th day of February, 2004, to:

21 Shain A. Cuber, M.D.
22 Address of Record

23 Suz McGowan
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